

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155258		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2011	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DRIVE ANDERSON, IN46016			
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 20, 21, 22, and 23, 2011</p> <p>Facility number: 000160 Provider number: 155258 AIM number: 100267190</p> <p>Survey team: Donna M. Smith, RN, TC Toni Maley, BSW Tammy Alley, RN</p> <p>Census bed type: SNF/NF: 92 Total: 92</p> <p>Census payor type: Medicare: 39 Medicaid: 43 Other: 10 Total: 92</p> <p>Sample: 19 Supplemental sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>			F0000	<p>Ms. Kim Rhoades Indiana State Department of Health Long Term Care Division 2 N. Meridian Stt. Indianapolis, IN 46204-3006</p> <p>July 8, 2011</p> <p>Dear Ms. Rhoades:</p> <p>Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on June 23, 2011. This letter is to inform you that the plan of correction attached is to serve as Countryside Manor Health & Living Community's credible allegation of compliance. We allege compliance on July 23, 2011. We are requesting a desk review for this plan of correction. If you have any further questions please do not hesitate to contact me at (765) 649-4558.</p> <p>Sincerely,</p> <p>Stephanie Ingram H.F.A. Administrator</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0157 SS=D	<p>Quality review completed 6/28/11 Cathy Emswiler RN</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the</p>			F0157	F157		07/23/2011

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	<p>facility failed to ensure the physician was notified when indicated for high blood sugar results for 1 of 7 residents reviewed for physician notification of blood sugars in a sample of 19. (Resident # 6)</p> <p>Findings Include:</p> <p>The record for Resident # 6 was reviewed on 6/20/11 at 2:30 p.m. The resident's current diagnoses included, but were not limited to, Diabetes.</p> <p>Current physician orders indicated an order to notify the physician if blood sugar is less than 60 or greater than 350 as a nursing measure. The original date of order was 5/15/11.</p> <p>The May 2011 Medication Administration Record (MAR) indicated on 5/24/11 at 8 p.m., the residents's blood sugar was 352. On 5/29/11 at 4 p.m., the resident's blood sugar was 480. At 8 p.m., the resident's blood sugar remained high at 379. The record lacked physician notification of any the high blood sugars.</p> <p>On 6/21/11 at 4:45 p.m., additional information was requested from the Director of Nursing regarding the lack of physician notification of the high blood sugars.</p>				<p>I. The M.D. for patient #6 has been notified. 1:1 inservicing has been provided for the nurse/nurses who did not notify the MD of the blood sugar outside of the ordered parameters.</p> <p>II. Current diabetic patients with accuchecks and blood sugar parameters will be reviewed for the last 30 days to determine if any other patients had blood sugars outside of the parameters. This review will include determining appropriate M.D. notification. Any identified patients will have M.D. notification.</p> <p>III. A systemic change included that all patients with a blood sugar outside of the ordered parameters will be recorded on a physician telephone order form. Physician orders will be reviewed daily (Monday through Friday) by the Unit Manager or designee to determine that appropriate M.D. notification has occurred. Training will be provided to licensed nurses on appropriate notification of physician for blood sugars outside of the ordered parameters. The training will also include recording patient change of condition on a physician order form.</p> <p>IV. The Director of Nursing and /or designee will review all accucheck results daily (Monday - Friday) for patients with blood sugars outside of the ordered parameters. The review</p>		

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F0167 SS=C	<p>On 6/22/11 at 8:50 a.m., during interview, the Director of Nursing indicated she was unable to locate the physician notification and the facility should follow the physician's call parameters.</p> <p>An undated policy titled "Diabetes Mellitus-Routine Care" was provided by the Director of Nursing on 6/22/11 at 9 a.m., and deemed as current.</p> <p>The policy indicated: "...An abnormal lab or blood glucose must be called to the physician...."</p> <p>3.1-5(a)</p>				<p>will occur for 100% of patients with accuchecks for one month, then weekly for the next month, then monthly for the next ten months, to total twelve months of monitoring. Any identified concerns will be addressed immediately. The results of these reviews will be reported to the Quality Assurance Committee.</p> <p>V. Completion date: 7/23/2011</p>		
	<p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on record review and interview, the facility failed to ensure the most recent</p>			F0167	<p>F167 I. The survey results for the previous 12 months have been placed in the survey book in the</p>		07/23/2011

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	<p>survey results were available for review for 4 of 4 survey days. The deficit practice had to potential to impact 92 of 92 residents residing in the facility.</p> <p>Findings include:</p> <p>On 6/20/11 at 10:15 a.m., the Survey Book located at the reception desk was reviewed. The book had the last annual and post survey re-visit included dated 5/27/10 and 7/8/10. The last complaint surveys which were completed on 7/29/10, 8/10/10 and 11/30/10, were not available in the book. On the subsequent days of the survey June 21, 22, and 23, 2011, the complaint surveys were not in the book.</p> <p>On 6/23/11 at 8:30 a.m., the Administrator was informed the complaint surveys were not in the book. During interview at that time, she indicated they should be in the book and she thought someone had placed them in the book.</p> <p>3.1-3(b)(1)</p>				<p>main lobby. II. No residents have been affected. III. The systemic change will be that the survey book will be reviewed on a scheduled basis to ensure the results of surveys for the previous 12 months are in the survey book. IV. The Administrator/Designee will review the survey book once a week for 30 days, then bi-monthly for the next month, then monthly for the remaining ten months, to total 12 months of monitoring. Any identified concerns will be addressed immediately. The results of these reviews will be forwarded to the Quality Assurance Committee. V. Completion date: 7/23/2011.</p>		

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F0176 SS=D	<p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observations, interview, and record review, the facility failed to ensure a resident was assessed concerning self-administration of respiratory medications for 2 of 4 residents observed receiving respiratory medications in a sample of 19. (Resident #51 and #32)</p> <p>Findings include:</p> <p>1. On 6/20/11 at 12:20 p.m., Resident #51 was observed receiving her nebulizer treatment in her room. No nursing staff was observed present in the room. At this same time during an interview, LPN #9, who was standing at the nurse's station, indicated she was planning on going back into the resident's room as she finished her task with the medication cart.</p> <p>Resident #51's record was reviewed on 6/21/11 at 1:30 p.m. The resident's diagnoses included, but were not limited, chronic obstructive pulmonary disease and asthma.</p> <p>The physician's order, dated 5/09/11, was Ipratropium/solution Albuterol (Duoneb)</p>			F0176	<p>F176</p> <p>I. Patient # 51 and #32 have been assessed for self administering of respiratory medications. 1:1 education has been provided to nurse #9 on self administration of respiratory medications.</p> <p>II. Patients with current orders for respiratory medications were assessed for self administration. Patients who are assessed to be capable of self administering their own respiratory medications, will have their M.D. notified and request that an order be given for them to be able to self administer their respiratory medications.</p> <p>III. The systemic change will include the self administration of medication assessment to be included in all new admission assessments for residents with respiratory inhalers. The self administration of medication assessment will also become a routine assessment with each Minimum Data Set for those residents with respiratory inhalers. Training will be provided to licensed nurses for the completion of the self administration of medications assessments. Training will also include proper technique and time frames of handheld inhalers as well</p>		07/23/2011

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	<p>(to aide in respiratory function) use contents of one vial per nebulizer 4 times a day.</p> <p>No information was indicated concerning a self medication assessment and/or physician order to self administer medication.</p> <p>2. On 6/22/11 from 8:05 a.m. to 8:35 a.m., medication pass was observed. After preparing her medications, LPN #9 was observed to hand Resident #32 her Pulmicort Flexhaler (to aide in respiratory function). As LPN #9 entered the bathroom to wash her hands, the resident was observed to administer 1 puff by mouth followed by a quick second puff. As LPN #9 returned to the bedside, she handed Resident #32 her Spiriva Inhaler (to aide in respiratory function), which was observed to be administered by the resident. No instructions were given to the resident as she took her respiratory medications.</p> <p>Resident #32's record was reviewed on 6/20/11 at 3:10 p.m. The resident's diagnoses included, but were not limited to, pneumonia, congestive heart failure, morbid obesity, and acute chronic obstructive pulmonary disease with hypoxemia.</p>				<p>as patient education for their use.</p> <p>IV. Medication pass observations will be conducted four times per week with licensed nurses for administration of respiratory medications for one month, then weekly for the next month, then monthly for the next ten months to total twelve months of monitoring. Any identified concerns will be addressed immediately. The results of these reviews will be reported to the Quality Assurance Committee.</p> <p>V. Completion date: 7/23/2011.</p>		

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	<p>The physician order, dated 5/12/11, were Pulmicort Inhaler 180 micrograms inhale 1 puff twice daily and Spiriva capsule handinhale inhale contents of 1 capsule by mouth once daily.</p> <p>No information was indicated related to a self medication assessment and/or physician order.</p> <p>On 6/22/11 at 2:12 p.m. during an interview, the Director of Nursing indicated Resident #32 did not have an assessment for a self medication administration until it was completed today.</p> <p>3. The "Self-Administration of Drugs" policy was provided by the Director of Nursing on 6/22/11 at 2:15 p.m. This current policy indicated the following:</p> <p>"Policy Statement Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so.</p> <p>Policy Interpretation and Implementation</p> <p>1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of</p>						

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	self-administering medications. ...3. If the staff determine that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications....." The "MEDICATION ADMINISTRATION: GENERAL POLICIES & PROCEDURES" policy was provided by the Director of Nursing on 6/22/11 at 2:15 p.m. This current policy indicated the following: "...Administration: ...11. Residents are not allowed to self-administer any medication unless specifically authorized to do so by the interdisciplinary team (IDT) and the attending physician....." 3.1-11(a)						

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F0177 SS=D	<p>An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a SNF, from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or a resident of a NF, from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.</p> <p>A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits. Based on observation, interview and record review, the facility failed to ensure residents where not required to move to a different area of the facility when the resident became non-eligible for therapy services for 1 of 2 residents reviewed for room transfers in a sample of 19. (Resident #46)</p> <p>Findings include:</p> <p>Resident #46's record was reviewed on 6/20/11 at 11:05 a.m. Resident #46's current diagnoses included, but were not limited to, depression, hypertension and diabetes mellitus.</p> <p>Resident #46 had a 1/5/11, "Intrafacility Transfer Notice" which indicated, "Resident requests room transfer due to plans to stay long term." The form indicated the resident was moving from</p>			F0177	<p>F177</p> <p>I. Resident #46 has been interviewed regarding her agreement with current room placement. As room preference becomes available, the resident will be moved if necessary.</p> <p>II. Intra-facility transfers from the last 30 days have been identified. Residents identified will be interviewed regarding their agreement with current room placement.</p> <p>III. The systemic change includes that intra-facility transfers will be provided only when voluntary, or when necessary to meet the residents' needs. Education has been provided to Social Services regarding proper intra-facility transfers only when voluntary or when necessary to meet the residents' needs.</p> <p>IV. The administrator or designee will review the intra-facility transfer</p>		07/23/2011

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2011

FORM APPROVED

OMB NO. 0938-0391

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	<p>the 300 hall to the 200 hall.</p> <p>During a 6/23/11, 10:10 a.m., interview with Resident #46's family member, who makes decisions regarding the residents care, the family member indicated, Resident #46 had changed rooms from the 300 hall to the 200 hall "because she was not longer receiving rehab services and would become a permanent patient and they (the facility) do not take medicaid on that side (300 hall) of the building. They keep it (the 300 hall) rehab."</p> <p>Review of a 6/20/11, facility completed "Bed Inventory" form indicated the facility had 109 licensed beds. All 109 beds were dually certified indicating residents who resides in those beds could have their stay paid for by, Medicaid, Medicare, private pay and/or private insurance as applicable.</p> <p>Review of a current facility booklet titled "Countryside Manor Health & Living Community-Guide to Community Living", which was provided by the Administrator on 6/20/11 at 10:35 a.m., indicated the following:</p> <p>"Transitional Care Unit Agreement ...Should you,...determine that you would benefit from additional long-term services upon completion of your short term</p>				<p>form for verification of reason for each transfer.</p> <p>Any identified concerns will be addressed immediately. The results of these reviews will be reported to the Quality Assurance Committee.</p> <p>V. Completion date: 7/23/2011.</p>		

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	<p>rehabilitation, a conference will be held to discuss those needs. At that time, you will be transferred to a suite...create a more home-like atmosphere for your longer-term stay. This discussion will take place a minimum of 24-hours prior to the end of your rehabilitation stay."</p> <p>During the initial tour and initial observation of the facility on 6/20/11 at 9:30 a.m. the 300 unit had carpeted halls, tan/taupe walls in the resident rooms. Resident rooms had multicolored green, gold and burgundy fall colored matching bed spreads and cornice window treatments, decorative framed art in the above color scheme and synthetic wood floors. Approximately 90% of the rooms had flat screen style television(s) either mounted on the wall or on a stand. During a 6/23/11, 12:45 p.m. interview, the Administrator indicated the flat screen televisions in the 300 hall resident rooms were provided by the facility.</p> <p>The 200 unit had cream flecked tiled floors in the hallway and resident rooms. The hallways were tan/taupe and cream. Resident rooms varied in color with non-matching bedspreads and window treatments. Some rooms did not have any window treatments and had blinds only. 5 rooms were noted to have flat screen televisions. During a 6/23/11, 12:45 p.m.</p>						

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F0223 SS=A	<p>interview, the Administrator indicated the facility had not provided televisions for the 200 hall resident rooms.</p> <p>3.1-12(a)(14)</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure residents were free from verbal abuse and intimidations for 1 of 7 residents reviewed for abuse prevention in a sample of 19 (Resident #60) and 1 of 2 residents reviewed for abuse prevention in a supplemental sample of 3 (Resident #200).</p> <p>Findings include:</p> <p>1.) Resident #200's closed record was reviewed on 6/22/11 at 8:20 a.m. Resident #200's diagnoses included but were not limited to, deaf, mute and depression.</p>			F0223	<p>F223</p> <p>I. C.N.A. #15 and C.N.A. #18 were terminated from employment following the investigated abuse allegations. Resident #200's family and MD were notified. Resident #200 was assessed for physical and emotional harm and found to be without injury or distress. Resident #60 was assessed for physical and emotional harm and found to be without injury or distress. The facility followed its' policy for the investigation of abuse.</p> <p>II. Other resident interviews were conducted with no concerns identified.</p>		07/23/2011

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	<p>Review of a 2/23/11, "Facility Incident Report Form" indicated the following:</p> <p>"Visitor witnessed staff member reacting inappropriately to patient [Resident #200] care needs. ...Preventive measures taken: Staff member suspended pending completion of investigation. ...2/28/11: Staff member [CNA #15] was terminated."</p> <p>Review of a, 2/23/11, facility "Resident Abuse Report Form Initial Report" indicated the following:</p> <p>"[Doctor's name] observed the CNA [#15] shake the pts [patient's] [Resident #200's] shoulders & then point her finger @ her poking her [Resident #200's] upper shoulder area p [after] pt voiced need to go to the bathroom. ...The employee [CNA #15] was immediately removed from patient care area, interviewed, suspended and sent home. "</p> <p>Review of a, 2/23/11, "Accident Investigation Form Unusual Occurrences" indicated the following:</p> <p>"...Staff Member was in room & witnessed pt [Resident #200] needing to go to the BR [bathroom] CNA [#15] said no you can wait & started to take pt out of room & pt grabbed the door the CNA then</p>				<p>III. The facility will continue to follow its' policy for the investigation of abuse.</p> <p>IV. Residents interviews are conducted to gauge resident satisfaction. Any concerns identified through this process are followed up on immediately.</p> <p>V. Completion date: 7/23/2011.</p>		

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	<p>placed her hands on the patient's [hands] jerked them off of the door brought her into the room & toileted her.</p> <p>...Pt [Resident #200] is non verbal but understands. She confirmed that the CNA [#15] shook her shoulders & pointed her finger @ her touching her shoulder & upper chest area."</p> <p>The report indicated:</p> <p>a.) The administrator was notified immediately</p> <p>b.) The resident involved, additional residents and staff were interviewed.</p> <p>c.) The resident's family and physician were notified</p> <p>d.) The resident was assessed for physical and emotional harm and found to be without injury or distress.</p> <p>e.) The staff member involved was suspended pending investigation and terminated following the investigation.</p> <p>f.) The facility followed it's policy for the investigation of abuse or neglect.</p> <p>e.) Current employees were re-educated to prevent future abuse.</p> <p>2. Resident #60's record was reviewed on 6/21/11 at 1:45 p.m. Resident #60's current diagnoses included, but were not limited to, chronic renal failure and dementia.</p>						

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	<p>Review of a 5/14/11, "Facility Incident Reporting Form" indicated the following:</p> <p>"On the morning of 5/14/11, facility staff overheard C.N.A. being verbally inappropriate with resident during AM care. ...Investigation showed that C.N.A. involved was verbally inappropriate with resident and this staff member was terminated. "</p> <p>Review of an undated form provided in association to the investigation of the above event titled "Staff interviews regarding the incident: indicated the following:</p> <p>LPN #10: Stated that "[CNA #8's] was yelling at [Resident #60] in his room and she [LPN #10] went in to assist in deescalating the situation. [LPN #10] stated that [CNA #8] was intimidating in her behavior and tone of voice. Stated [CNA #8] got right in [Resident #60's] face and was yelling at him. She [CNA #8] was using inappropriate language including saying the word f---ing several times."</p> <p>CNA #11: "Saw [CNA #8] go into [Resident #60's] room. Her her...yelling at [Resident #60]..."</p>						

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	<p>CNA #12: "Was in the room next door. She stated that she heard [CNA #8] yell at [Resident #60] 'I'm late today. I can't f---ing...(couldn't make out last part). I'm here to get you f---ing up. I'm sorry that I was f---ing late.' "</p> <p>Social worker #14: "I was walking outside [room number] when I heard [CNA #8] yelling in [Resident #60's room]. I heard her say 'I'm not dealing with this f---ing s--t today. I'm not dealing with your attitude today.' [CNA #8] came out of the room and yelled 'This place is f---ed up.' "</p> <p>The report indicated:</p> <ul style="list-style-type: none"> a.) The administrator was notified immediately b.) The resident involved, additional residents and staff were interviewed. c.) The resident's family and physician were notified d.) The resident was assessed for physical and emotional harm and found to be without injury or distress. e.) The staff member involved was suspended pending investigation and terminated following the investigation. f.) The facility followed it's policy for the investigation of abuse or neglect. e.) Current employees were re-educated to prevent future abuse. 						

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F0282 SS=E	Review of a current 4/2011, facility policy titled "Abuse Prevention", which was provided by the Administrator on 6/20/11 at 10:25 a.m., indicated the following: "...provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion..." During a 6/20/11, 9:30 a.m., interview, the Administrator indicated both CNA #15 and CNA #8 were terminated from employment following the above investigated abuse allegations. 3.1-27(b)						
	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review, observation and interview, the facility failed to ensure the plan of care was followed for the application of Thrombo-Embolitic Deterrent Hose (TED) (Resident # 24), completion of blood pressure, accuchecks			F0282	F282 I. Patient # 24's information regarding T.E.D hose has been placed on the C.N.A. assignment sheet. Patient # 6 orthostatic blood pressures have been completed per nursing measure. Patient # 32 accuchecks at 11am and HS have		07/23/2011

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	<p>and sliding scale insulin (Resident # 6, # 32, # 30, # 48 and #51) and completion of labs (Resident #30 and # 60) for 7 of 19 residents reviewed for following the plan of care in a sample of 19.</p> <p>Findings include:</p> <p>1. The record for Resident # 24 was reviewed on 6/20/11 at 11:30 a.m. Current physician orders for June 2011 indicated an order for TED hose to be on the right leg in the a.m. and off in the p.m. The original date of order was 5/10/11 indicating the resident had right lower extremity edema.</p> <p>On 6/20/11 at 10:50 a.m., during a dressing change observation, the resident was observed being transferred to bed and did not have a TED hose on his right leg. At that time, during interview, CNA # 1 indicated he did not have a TED hose on. She then checked her CNA assignment sheet and indicated TED hose was not on the assignment sheet.</p> <p>2. The record for Resident # 6 was reviewed on 6/20/11 at 2:30 p.m. Current diagnoses included, but were not limited to, hypotension.</p> <p>The nursing notes for 5/22/11 indicated the resident had a fall and went to the</p>				<p>been placed on a medication error report with family and MD notification. Resident #30 no longer resides at this community. Patient # 51 and patient # 48 sliding scale insulin administration has been placed on a medication error report with family and M.D. notification. These patients sliding scale orders have been clarified on the Medication Administration Record (M.A.R.) and will be administered as ordered. Patient # 60 and # 30's laboratory errors were placed on a medication error report with family and MD notification. There were no negative resident outcomes resulting from the above errors.</p> <p>II. Orders have been reviewed to identify patients requiring ted hose. This information has been added to the C.N.A. assignment sheet. Current patients with orthostatic blood pressures have been reviewed. Any identified concerns have been addressed. Current patients with accucheck orders have been reviewed and are on the M.A.R. to be received as ordered. Residents receiving sliding scale type insulins have had their M.A.R.s clarified and are receiving medication as ordered.</p> <p>III. The systemic change is that during the daily review of physician orders (Monday through Friday), if a patient receives an order for T.E.D. hose, this information will be placed on the C.N.A. assignment sheet</p>		

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	<p>emergency room for evaluation and returned to the facility.</p> <p>An order dated 5/23/11 indicated an order for orthostatic blood pressures (sitting then standing blood pressure checks) to be completed for 3 days.</p> <p>The May 2011 Medication Administration Record (MAR) indicated a single blood pressure was taken on 5/23/11-5/25/11.</p> <p>Additional information was requested from the Director of Nursing on 6/21/11 at 4:45 p.m., regarding the lack of orthostatic blood pressures.</p> <p>On 6/22/11 at 8:50 a.m., during interview, the Director of Nursing indicated orthostatic blood pressures were not completed for the 3 days.</p> <p>3. The record for Resident # 32 was reviewed on 6/20/11 at 3:10 p.m.</p> <p>Current diagnoses included, but were not limited to, diabetes.</p> <p>Current physician orders for June 2011 indicated an order for accuchecks to be completed before meals and at bedtime. Original date of the order was 5/12/11.</p> <p>The May and June 2011 Medication</p>				<p>at that time. Any new orders for accuchecks will be reviewed to ensure accurate transcription to the MAR/TAR. Orthostatic blood pressures will be documented on the "Orthostatic blood pressure form" to be completed by the licensed nurse. Format for sliding scale insulin has been clarified on the M.A.R. for proper identification of accurate insulin dosage. Laboratory requisitions will be completed to include the date that it is to be drawn if different from our regular lab draw days. Education will be provided to the lab provider, that labs should be drawn on next routine draw date scheduled, unless otherwise noted. Education has been provided to licensed nursing staff regarding administration of medications as ordered, clarifications of sliding scale insulin on the M.A.R., obtaining orthostatic blood pressures and procedure for lab requisitions.</p> <p>IV. Medication Administration Records will be audited for sliding scale insulin administration and proper transcription of physician orders. C.N.A. assignment sheets will be audited for addition of appropriate information. Lab requisitions will be audited to ensure proper lab draw dates. This will be reviewed five times per week for one month, then weekly for the next month, then monthly for the next ten months, to total twelve months of monitoring. Nurse manager or</p>		

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	<p>Administration Record (MAR) lacked accucheck results for 11 a.m., and at bedtime for May 13-June 21, 2011.</p> <p>Additional information was requested on 6/21/11 at 4:45 p.m., from the Director of Nursing regarding the lack of the above accucheck results.</p> <p>On 6/22/11 at 8:50 a.m., during interview, the Director of Nursing indicated she was unable to provide any of the above accuchecks.</p> <p>4. Resident #51's record was reviewed on 6/21/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetic mellitus.</p> <p>The physician order, dated 5/10/11, were glucometer (to check for blood sugars) before meals and at bedtime; Novolog sliding scale with the range of blood sugars of 151 - 200 = 2 units and 201 - 250 = 4 units.</p> <p>The "Medication Record" for May 2011 indicated on 5/13/11 at 4:00 p.m. indicated a blood sugar of 205 with 2 units of Novolog coverage insulin given.</p> <p>On 6/22/11 at 8:15 a.m. during an interview, the Director of Nursing</p>				<p>designee will be responsible. Any identified concerns will be addressed immediately. The results of these reviews will be reported to the Quality Assurance Committee.</p> <p>V. Completion date: 7/23/2011.</p>		

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	<p>indicated on 5/13/11 at 4:00 p.m. the resident should had received 4 units of insulin coverage with a blood sugar of 205.</p> <p>5. Resident #48's record was reviewed on 6/22/11 at 2:20 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus Type II.</p> <p>The physician's order, dated 4/13/11, was glucometer (blood sugar checks) before meals and at bedtime; Novolog insulin sliding scale with the range of blood sugars of 201 - 250 = 4 units and blood sugar of 251 - 300 = 6 units.</p> <p>The "Medication Record" for June 2011 indicated on 6/04/11 at 11:00 a.m. the blood sugar was 251 with 4 units given.</p> <p>On 6/22/11 at 8:15 a.m. during an interview, the Director of Nursing indicated on 6/04/11 at 11:00 a.m. the resident should had received 6 units of insulin coverage with a blood sugar of 251.</p> <p>6. Resident #30's record was reviewed on 6/22/11 at 2:25 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus.</p> <p>The physician's order, dated 6/07/11, was</p>						

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	<p>accuchecks before meals and at bedtime with Novolog sliding scale with the range of blood sugars of 141 - 240 = 2 units.</p> <p>The "Medication Record" for June 2011 indicated on 6/21/11 at 7:00 a.m. the blood sugar was 150 with no insulin coverage given.</p> <p>On 6/22/11 at 8:15 a.m. during an interview, the Director of Nursing indicated on 6/21/11 at 7:00 a.m. the resident should had received 2 units of insulin coverage with a blood sugar of 150.</p> <p>7. Resident #60's record was reviewed on 6/21/11 at 1:45 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure.</p> <p>The physician's order, dated 5/09/11, was to obtain a comprehensive metabolic panel (CMP) and a complete blood count (CBC) on 5/12/11.</p> <p>The laboratory studies indicated a CMP and CBC were obtained on 5/10/11 with no information of any laboratory studies were done on 5/12/11.</p> <p>On 6/22/11 at 8:45 a.m. during an interview, the Director of Nursing indicated the nurse, who had submitted</p>						

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	<p>the lab requisition to the lab, had not specify the date the labs were to be drawn. This resulted in the labs being drawn on 5/10 instead of 5/12 as ordered.</p> <p>8. Resident #30's record was reviewed on 6/22/11 at 2:25 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, anemia, hyperlipidemia, and hypertension.</p> <p>The physician order, dated 6/01/11, was to obtain a CBC (complete blood count) due to anemia, BMP (Basal Metabolic Panel) due to shortness of breath, magnesium level, and liver profile due to hyperlipidemia.</p> <p>No laboratory studies were completed on 6/01/11.</p> <p>The physician's progress notes, dated 6/09/11, indicated labs were not obtained on 6/03/11 as ordered.</p> <p>On 6/23/11 at 12:35 p.m. during an interview, the Director of Nursing indicated the laboratory orders were received on day shift and were left for the evening nurse to fax/complete the laboratory requisition. This was done at 11:00 p.m. on the same day but was too late for the next lab day's scheduled blood</p>						

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F0309 SS=D	<p>draw (6/03/11) resulting in the labs being drawn on 6/06/11. She also indicated the nurse receiving the laboratory orders should be completing the laboratory requisition order and faxing it to the lab.</p> <p>3.1-35(g)(2)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a one time medication was administered timely for nausea, (Resident # 46), and failed to ensure a resident with hyperglycemia was assessed for complications (Resident # 6) for 3 of 3 residents reviewed for appropriate administration of medication being implemented in sample of 19.</p> <p>Findings include:</p> <p>1.) Resident #46's record was reviewed on 6/20/11 at 11:05 a.m. Resident #46's current diagnoses included, but were not limited to, depression, hypertension and diabetes mellitus.</p>			F0309	<p>F309</p> <p>I. A medication error report has been completed for patient #46's omitted medication and patient # 6's blood sugar levels outside of the ordered parameters. Both MD and family have been notified. MD orders were clarified regarding residents #46 and #6.</p> <p>II. Patients with nausea symptoms have been identified with appropriate assessment as needed. Patients with blood sugar parameters have been identified and reviewed for clarification and will be administered as ordered.</p> <p>III. The systemic change is that all new orders will be read aloud during</p>		07/23/2011

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	<p>Resident #46 had a, 6/21/11, physician's order for "phenegran 25 mg (an anti-nausea medication) IM (intramuscular injection) 1 dose for nausea."</p> <p>Resident #46 had a, 5/9/11, upper endoscopy report which indicated the resident had an esophageal ring, hiatus hernia and reflux esophagitis.</p> <p>During a 6/22/11, 8:15 a.m. interview, Resident #46 indicated she was suppose to get a shoot for nausea yesterday and had not gotten it."</p> <p>Resident #46 had a 6/22/21, 8:34 a.m., nursing note which indicated it was a late entry for 6/21/11 at 8:00 a.m. The note indicated on 6/21/11 the resident had a small amount of emesis and complained of nausea.</p> <p>During a 6/22/11, 9:00 a.m., interview, the Director of nursing indicated Resident #46 had not been given her 1 time dose of phenegran 25 mg yesterday 6/21/11 when it was ordered. The Director of Nursing indicated the resident would receive the injection as soon as possible.</p> <p>During a 6/22/11, 2:30 p.m., interview, Resident #46 indicated she had received</p>				<p>the clinical meeting and will be evaluated by the clinical team. New orders will be verified by the Unit Manager daily (Monday through Friday).</p> <p>IV. Unit Manager/designee will audit new nausea and blood sugar orders daily (Monday through Friday) for one month, then weekly for one month, then monthly for the next ten months, to total twelve months of monitoring.</p> <p>Any identified concerns will be addressed immediately. The results of these reviews will be reported to the Quality Assurance Committee.</p> <p>V. Completion date: 7/23/2011.</p>		

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	<p>her injection that morning after our previous conversation and the shot may have helped a little bit; but she was still experiencing some nausea and vomiting.</p> <p>2. The record for Resident # 6 was reviewed on 6/20/11 at 2:30 p.m. Current diagnoses included, but were not limited, Diabetes.</p> <p>Current physician orders indicated an order to notify the physician if blood sugar is less than 60 or greater than 350 as a nursing measure. The original date of the order was 5/15/11.</p> <p>The May 2011 Medication Administration Record (MAR) and the nursing notes indicated the following:</p> <p>On 5/24/11 at 8 p.m., the residents's blood sugar was 352. There was no assessment or follow up documentation on the resident's condition or blood sugar.</p> <p>On 5/29/11 at 4 p.m., the resident's blood sugar was 480. There was no assessment or follow up on the blood sugar or resident condition. At 8 p.m., the resident's blood sugar remained high at 379. Again there was not follow up assessment or blood sugar.</p> <p>On 6/22/11 at 2:15 p.m., the Director of Nursing indicated with high blood sugars</p>						

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F0315 SS=D	<p>the resident should be assessed and the blood sugar should be rechecked in 15 minutes.</p> <p>3.1-37(a)</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review, observation, and interview, the facility failed to ensure anchored catheter tubing and drainage bag was positioned off the floor to prevent the possibility of infection for 1 of 2 residents with anchored catheters in a sample of 19. (Resident # 32)</p> <p>Findings include:</p> <p>1. The record for Resident # 32 was reviewed on 6/20/11 at 3:10 p.m. Current physician orders for June 2011, indicated</p>			F0315	<p>F315</p> <p>I. Patient #32's foley catheter tubing has been re-positioned off of the floor. C.N.A. was educated on proper positioning of foley catheter tubing and drainage bag.</p> <p>II. Patients with foley catheters have been identified and are monitored for correct positioning of catheter tubing.</p> <p>III. The systemic change will include that Charge nurses will complete rounds to observe that each foley catheter bag and tubing are</p>		07/23/2011

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	<p>an order for an anchored catheter.</p> <p>A plan of care dated 4/1/11 indicated the resident had an anchored catheter and was at risk for infection. Approaches to the plan of care included, but were not limited to, do not allow the drainage tubing or drainage system to touch the floor.</p> <p>On 6/20/11 at 12:05 p.m., during a transfer observation of Resident # 32, CNA # 1 assisted the resident to sit on the side of the bed. As the resident sat up the anchored catheter tubing was on the floor. The CNA then placed the anchored catheter drainage bag on the side lower bar of the resident's walker. The anchored catheter drainage bag and tubing were resting on the floor. There was urine in the tubing. After the resident was transferred into her wheelchair, the CNA placed the drainage bag and tubing on the floor under the resident's wheelchair and dragged them on the floor to where she could reach them and then placed the drainage bag into the dignity bag on the wheelchair.</p> <p>After the observation, during interview, the CNA indicated the anchored catheter tubing and drainage bag should not be on the floor.</p> <p>On 6/20/11 at 3:05 p.m., the resident was</p>			<p>positioned and handled in a manner to prevent urinary tract infections. Any issues identified will be addressed immediately. Education has been provided to nursing staff on proper positioning and handling of foley catheter tubing.</p> <p>IV. The Nurse manager/designee will monitor foley catheter tubing and bag positioning four times per week for one month, then weekly for one month, then monthly for the next ten months to total twelve months of monitoring. Any identified concerns will be addressed immediately. The results of these reviews will be reported to the Quality Assurance Committee.</p> <p>V. Completion date: 7/23/2011.</p>			

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F0328 SS=D	<p>in the small dining room in her wheelchair. The anchored catheter tubing was on the floor under the wheelchair.</p> <p>On 6/20/11 at 5:45 p.m., the resident was in her room in her wheelchair receiving a respiratory treatment. The resident's anchored catheter tubing was on the floor under the resident's wheelchair. At that time, LPN # 2 was informed the anchored catheter tubing was on the floor.</p> <p>2. A 2010 policy titled "Catheter Care, Urinary" was provided by the Director of Nursing on 6/22/11 at 9 a.m., and deemed as current. The policy indicated: "Purpose The purpose of this procedure is to prevent catheter-associated urinary tract infections...Infection Control...Be sure the catheter tubing and drainage bag are kept off the floor...."</p> <p>3.1-41(a)(2)</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p>						

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	<p>Based on record review and interview, the facility failed to ensure oxygen was administered as ordered by the physician for 1 of 3 resident's reviewed for oxygen administration in a sample of 19. (Resident # 32)</p> <p>Findings include:</p> <p>The record for Resident # 32 was reviewed on 6/20/11 at 3:10 p.m. Current diagnoses included, but were not limited to Chronic Obstructive Pulmonary Disease (COPD).</p> <p>Current physician orders for June 2011 indicated an order for oxygen at 4 liters by nasal canula. Original date of order was 3/28/11.</p> <p>A nursing note dated 5/13/11, late entry for 5/12/11, indicated the resident's oxygen saturations were 79-80 %. The note indicated the oxygen was turned up to 4 liters, then 6 liters, then to 8 liters with no improvement. The resident's son was present and requested the resident be sent to the emergency room. The resident was sent to the emergency room. A nursing note dated 5/13/11 at 11:31 p.m., indicated the resident returned from the hospital with a diagnoses of pneumonia.</p> <p>Additional information was requested</p>			F0328	<p>F328</p> <p>I. Resident #32's oxygen is set to the physician ordered setting. An assessment has been completed to determine the patients oxygen level needs. The nurse received 1:1 education on the Diagnosis of COPD and oxygen administration to such patients and following MD orders.</p> <p>II. Current patients with oxygen orders have been identified and their settings verified.</p> <p>III. The systemic change is to now communicate the oxygen order on the TAR (Treatment Administration Record) for the nurse's reference. Licensed nurses have been educated on oxygen rates to be placed on the TAR and to follow physician orders for appropriate oxygen liter flow. Licensed nurses will also be educated on oxygen use for COPD patients.</p> <p>IV. Nurse manager/designee will audit patients' oxygen levels five times per week for one month, then weekly for one month, the monthly for the next ten months to total twelve months of monitoring. Any identified concerns will be addressed immediately. The results of these reviews will be reported to the Quality Assurance Committee.</p> <p>V. Completion date: 7/23/2011.</p>		07/23/2011

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F0332 SS=D	<p>from the Director of Nursing on 6/21/11 at 4:45 p.m., regarding the increase in the oxygen flow rate.</p> <p>On 6/22/11 at 8:50 a.m., during interview, the Director of Nursing indicated the oxygen flow rate should not go above 4 liters for a resident with COPD. She indicated the nurse who had turned up the flow rate was a new and would be educated.</p> <p>The Lippincott Manual of Nursing Practice Handbook Third Edition, indicated on page 212 that "...giving a high oxygen concentration may remove the hypoxic drive, leading to hypoventilation, respiratory decompensation, and the development of worsening respiratory acidosis...."</p> <p>3.1-47(a)</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observations, record reviews, and interview, the facility failed to ensure it was free of a medication error rate of 5% or greater for 3 of 40 opportunities during 2 of 6 nursing staff observed and for 2 of 8 residents observed during</p>			F0332	<p>F332</p> <p>I. LPN's # 4, 5, and RN #6 received 1:1 education regarding correct procedure for medication administration. LPNs #4, 5 and RN # 6 will have medication administration observation to</p>		07/23/2011

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	<p>medication pass. The medication error rate was 7.5 %.</p> <p>(LPN #4 and #5)</p> <p>(Resident #'s 83, 84, and 48)</p> <p>Findings include:</p> <p>1. On 6/20/11 from 4:10 p.m. to 5:00 p.m., medication pass was observed. The following was observed:</p> <p>a.) First, LPN #4 was observed to prepare Resident #83's medications. These medications were Xopenex (to treat bronchospasm) 1.25 mg (milligrams)/3 ml (milliliter) 1 ampule (amp) per nebulizer 4 times a day and Ipratropium Bromide Inhalation Solution (to aide respiratory function) 0.02% 0.5 mg/2.5 ml 1 vial in nebulizer 4 times a day. The resident was observed to receive the Xopenex per nebulizer followed by the Ipratropium Bromide medication per nebulizer.</p> <p>Resident #83's record was reviewed on 6/22/11 at 2:00 p.m. The resident's diagnoses included, but were not limited to, pneumonia and chronic obstructive pulmonary disease (COPD).</p> <p>The physician's order, dated 6/04/11 at 3:00 a.m., was Duoneb (to aide in respiratory function) per nebulizer every 6 hours while awake.</p>				<p>determine compliance with policy.</p> <p>II. Licensed nursing staff will be observed for medication administration. Any identified issues will be addressed immediately and re-education will be completed.</p> <p>III. Education will be provided to licensed nurses and QMAs regarding appropriate medication administration and will include the following:</p> <ul style="list-style-type: none"> *The 5 rights of medication administration *Insulin types and peak times *Accurate documentation. <p>IV. Assistant Director of Nursing/designee will audit by observation of medication administration five times per week for one month, then weekly for one month, then monthly for the next ten months, to total twelve months of monitoring. Any identified concerns from audits will be addressed immediately.</p> <p>The results of these reviews will be reported to the Quality Assurance Committee.</p> <p>V. Completion date: 7/23/2011.</p>		

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	<p>The physician's order, dated 6/04/11 at 8:15 a.m., was to discontinue the Duoneb. The physician's order, dated 6/04/11 at 9:00 a.m., was to sent the resident to the emergency room to evaluate and treat. The hospital discharge orders, dated 6/09/11, included, but were not limited to, Xopenex 1.25 mg 4 times daily per nebulizer. No physician order was indicated for the Ipratropium Bromide and/or Duoneb.</p> <p>On 6/21/11 at 9:30 a.m. during an interview, Unit Manager #20 indicated Resident #83's Ipratropium Bromide nebulizer treatment was discontinued on 6/04/11 and was not reordered after the resident's return from the hospital on 6/09/11.</p> <p>b.) Then, LPN #4 was observed to prepare Resident #84's insulin medication. LPN #4 was observed to obtain 8 units (u) of Novolog insulin (to regulate blood sugars) for subcutaneous injection. At this same time during an interview, LPN #4 indicated the peak level for this insulin was 30 minutes and she felt safe giving it to the resident as this time as dinner was scheduled at 5:30 p.m. The insulin was observed given to the resident at 4:47 p.m.</p> <p>Resident #84's record was reviewed on 6/22/11 at 2:10 p.m. The resident's</p>						

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	<p>diagnoses included, but were not limited to, diabetes.</p> <p>The physician's order, dated 4/21/11, was Novolog Injection 100/milliliter inject 8 units subcutaneously 3 times daily before each meal.</p> <p>On 6/20/11 at 6:15 p.m. during an interview, CNA #19 indicated she began to serve the room trays at 5:40 p.m. At this same time, Resident #84 was observed in her room with a room tray. She was observed to had eaten only her biscuit and also indicated at this time she was "full."</p> <p>c.) Next, LPN #5 was observed to pass Resident #48's medication. LPN #5 indicated the accucheck resulted in a blood sugar of 341 requiring insulin coverage. After preparing 8 units of Novolog insulin (to regulate blood sugars) in a syringe, LPN #5 was observed to give Resident #48 her insulin coverage at 5:00 p.m.</p> <p>Resident #48's record was reviewed on 6/22/11 at 2:20 p.m. The resident's diagnoses included, but were not limited to, Diabetes Mellitus Type II.</p> <p>The physician order, dated 4/13/11, was Novolog injection 100/milliliter inject</p>						

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	<p>subcutaneously per sliding scale; accucheck before meals and at bedtime; blood sugar 301 to 350 = 8 units.</p> <p>On 6/20/11 starting at 5:45 p.m., the first meal tray was observed to be served in the main dining room.</p> <p>On 6/20/11 at 5:53 p.m., Resident #48 did not have her meal tray as she waited in the main dining room. On this same day at 6:10 p.m., Resident #48 was observed to be eating her requested 2 hot dogs.</p> <p>2. The 2010 Nursing Spectrum Drug Handbook indicated Novolog was a short acting insulin. The administration of Novolog was to be given 5 to 10 minutes before a meal if given by the subcutaneous route.</p> <p>The "DIABETIC MELLITUS - ROUTINE CARE" policy was provided by the Director of Nursing on 6/22/11 at 2:15 p.m. This current policy indicated the following:</p> <p>"Purpose: To provide nursing staff with guidelines for implementing care for the resident with diabetes mellitus.</p> <p>Objective: To provide care that will enable the resident to achieve and or maintain control of diabetes and to</p>						

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	<p>function safely in its natural environment.</p> <p>...MEDICATION ...Insulin needs to be given 30 minutes before the scheduled meal..."</p> <p>The "MEDICATION ADMINISTRATION: GENERAL POLICIES & PROCEDURES" policy was provided by the Director of Nursing on 6/22/11 at 2:15 p.m. This current policy indicated the following:</p> <p>"POLICY</p> <p>...All medications are to be administered only as prescribed by a physician..."</p> <p>The meal times were provided by the Administrator on 6/20/11 at 10:25 a.m. The dinner meal time was indicated as 6:00 p.m. in the dining room.</p> <p>3.1-48(c)(1)</p>						

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F0441 SS=F	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observations, interview, and record review, the facility failed to ensure infection control practices were followed in a manner to prevent the potential for the spread of infections and diseases</p>			F0441	<p>F441 I. Residents # 31, 83,84,48,59, 30, 37 and 32 were reviewed and have had no signs or symptoms of infection requiring antibiotic use since survey completion.</p>		07/23/2011

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	<p>concerning 3 of 3 Laundry Aides (Laundry Aide #'s 16, 17, and 18) for 3 of 3 observations of personal clothing being delivered, and concerning handwashing, medication handling, and equipment handling during medication pass observation for 6 of 6 nursing staff ((LPN #'s 3, 4, 5, 7, 9; RN #6) observed for 8 of 8 residents (Resident #'s 31, 83, 84, 48, 59, 30, 37, and 32) observed during medication pass. This deficient practice had the potential to impact 58 of 92 residents, who had the facility launder their personal clothing.</p> <p>B. Based on record review and interview, the facility failed to implement an infection control program which included tracking, trending, and follow up concerning any infectious patterns. This deficient practice had the potential to impact 92 of 92 residents.</p> <p>Findings include:</p> <p>A. 1. On 6/20/11 at 5:20 p.m., Laundry Aide #16 was observed to be passing personal clothing from room to room down the 300 hallway. The one side of the laundry cart remained opened during this observation.</p> <p>A. 2. On 6/20/11 at 5:45 p.m., Laundry Aide #17 was observed to be passing</p>				<p>The infection log for June has been completed with room numbers, infection type and date of resolution. Laundry staff identified were educated on appropriate linen handling for delivery of personal clothing. Nursing staff identified were educated on hand washing procedure, glove use and appropriate infection control practice during medication pass.</p> <p>II. No other residents were affected by the deficient practice. A review of antibiotic use was conducted with no correlation to the deficient practice. Laundry staff were educated on appropriate linen handling for delivery of personal clothing. Nursing staff were educated regarding hand washing procedure, glove use, linen handling and appropriate infection control practice during medication pass.</p> <p>III. Systemic change includes that staff were educated on hand washing procedure, glove use and appropriate infection control practice during medication pass. Identification of trends for infections will occur with review of physicians orders. Trends will be addressed upon identification. Laundry staff will pass resident personal clothing with cart closed.</p> <p>IV. The Assistant Director of</p>		

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	<p>personal clothing from room to room down the 200 hallway with the one side of the laundry cart remaining open. At this same time during an interview, LA #17 indicated the personal clothing should be covered as it was being transported/delivered to the resident's rooms. She also indicated while passing linen, she would place items on top of the cart preventing her from closing the linen cart. Several folded items were observed presently on the top of the covering for the linen cart.</p> <p>A. 3. On 6/21/11 at 7:55 a.m., Laundry Aide #18 was observed to be passing personal clothing from room to room down the 200 hallway with one side of the laundry cart remaining open.</p> <p>A. 4. On 6/20/11 at 11:05 a.m., Resident #30's accucheck was completed by LPN #3. After showing the resident his blood sugar results, LPN #3 was observed to handwash, turn the water off with her wet hand and then, dried her hands.</p> <p>A.5. On 6/20/11 at 12:05 p.m., medication pass was observed. In preparation, LPN #3 was observed to handwash for less than 10 seconds, turn the water off with her wet hand, and then, dried her hands. She then proceeded to administer Resident #31 his prepared</p>				<p>Nursing/designee will audit through direct observations of hand washing procedure, glove use and appropriate infection control practice during medication pass five times per week for one month, once per week for the next month, then monthly for the next ten months, to total twelve months of monitoring. Any identified concerns from audits will be addressed immediately. The results of these reviews will be reported to the Quality Assurance Committee.</p> <p>V. Completion date: 7/23/2011</p>		

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	<p>insulin in his abdomen.</p> <p>On 6/21/11 at 9:10 a.m. during an interview, LPN #3 indicated one should handwash for 30 seconds, rinse one's hands, dry them, and turn the faucet off with paper towels.</p> <p>A. 6. On 6/20/11 from 4:10 p.m. to 5:00 p.m., medication pass was observed. The following was observed:</p> <p>After LPN #4 prepared and administered Resident #83's medication of Xopenex (to prevent bronchospasms) followed by the medication, Ipratropium Bromide (to aide in respiratory function), LPN #4 placed the nebulizer administration unit (mouthpiece and medication cup) into the plastic bag on the bedside table. No cleansing of the nebulizer's administration unit was observed between medications or after the medications were completed.</p> <p>Then, after LPN #4 was observed to prepare Resident #84's insulin (to regulate blood sugars) medication, she handwashed for less than 10 seconds, turned the water off with her wet hands, and then, dried her hands before donning a pair of gloves. Next, LPN #4 administered the insulin subcutaneously in the abdomen, removed her gloves, and handwashed for less than 10 seconds to</p>						

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	<p>complete her task.</p> <p>Next, LPN #5 was observed to prepare Resident #48's insulin medication. After donning a pair of gloves, she administered Resident #48's insulin medication subcutaneously in the abdomen. LPN #5 then removed her gloves disposing of them in the bathroom, returned to her medication cart and prepared and administered the resident's oral medication, Warfarin (blood thinner). As she exited Resident #48's room, Resident #59 requested to go down to the dining room. LPN #5 proceeded to wheel the resident down the hallway in her wheelchair towards the dining room. No handwashing or handgel use was observed.</p> <p>A. 7. On 6/20/11 from 5:00 p.m. to 5:15 p.m., Resident #30's accucheck was observed. RN #6 was observed to complete the resident's accucheck, remove her gloves, handwashed less than 5 seconds, turn the water off with her wet hand, and then dried her hands. At this same time during an interview, RN #6 indicated one should handwash for 30 seconds, rinse one's hands, dried one's hands, and then, turn the water off with the paper towels.</p> <p>A. 8. On 6/20/11 from 5:05 p.m. to 5:15</p>						

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	<p>p.m., medication pass was observed. RN #6 was observed to prepare and administer Resident #30's insulin in the abdomen. She was observed to handwash for less than 10 seconds, turned the water off with her wet hand, and then dried her hands.</p> <p>A. 9. On 6/21/11 from 8:30 a.m. to 9:07 a.m., medication pass was observed. In preparation, LPN #7 was observed to prepare Resident #37's oral medications. During this observation, LPN #7 was observed to direct with her bare finger from the packaging the Ferrous Gluconate (iron supplement) tablet and the Vitamin E pill into the medication cup. Also, when the Sprionolactone (hypertension) pill fell onto the medication's cart top, LPN #7 picked it off of the medication cart top and placed it in the medication cup with the rest of the oral medications. These oral medications were observed given by LPN #7 to Resident #37. Next, LPN #7 completed Resident #37's nebulizer treatment. She was observed to handwash, turn the water off with her wet hand, and then, dried her hands.</p> <p>A. 10. On 6/22/11 from 8:05 a.m. to 8:35 a.m., medication pass was observed. As LPN #9 was observed preparing the resident's oral medications, she was observed to drop the Omeprazole</p>						

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	<p>(gastroesophageal reflux disease) capsule on top of her report paper laying on top of the medication cart. This same pill was then picked up with the same pill's paper cover and put it in the medication cup with the rest of the oral medications. Upon entering Resident #32's room, the resident's administration nebulizer unit (mouthpiece and medication container) were observed on top of the resident's beside table uncovered. At this same time during an interview, LPN #9 indicated the resident will set it on the table after she was done with her nebulizer treatment. Also, an orange colored pill dropped from the medication cup onto the floor. LPN #9 proceeded to pick this same pill off of the floor, obtained another orange colored pill from the medication cart, placed it into the same medication cup. After handing the resident her inhalers, LPN #9 then handwashed for less than 10 seconds. After the resident had administered her inhalers, LPN #9 gave the resident her oral medications, handwashed for less than 10 seconds, completed the resident's accucheck, and again, handwashed for less than 10 seconds. At this same time during an interview, LPN #9 indicated one should handwash for 15 seconds, and the dropped medications on the top of the medication cart should had been thrown away and not used.</p>						

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	<p>A. 11. The following current policies were provided by the Director of Nursing on 6/22/11 at 2:15 p.m.</p> <p>The "Handwashing/Hand Hygiene" policy indicated the following:</p> <p>"5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:</p> <p>...c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice);</p> <p>d. Before and after performing any invasive procedure (e. g., fingerstick blood sampling);</p> <p>...u. After removing gloves or aprons; and</p> <p>v. After completing duty.</p> <p>...Procedure</p> <p>Washing Hands</p> <p>...2. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least fifteen (15) seconds...</p> <p>3. Rinse hands thoroughly under running water....</p> <p>4. Dry hands thoroughly with paper towels and then turn off faucets with a</p>						

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	<p>clean, dry paper towel....."</p> <p>The "Personal Protective Equipment - Using Gloves</p> <p>...5. Wash hands after removing gloves. (Note: Gloves do not replace handwashing.)...."</p> <p>The "MEDICATION ADMINISTRATION: GENERAL POLICIES & PROCEDURES" policy indicated the following:</p> <p>"...Administration</p> <p>...15. Hands shall be washed after a med pass is completed with one resident and before commencing a med pass with the next resident.</p> <p>a) Hands may be cleaned with an alcohol-based gel or foam cleanser in between residents during med pass per manufacturer's guidelines.</p> <p>...c) In all cases when gloves are used in the process of administering medications, hands should be washed with soap and water prior to and after the gloving....."</p> <p>The "Nebulizer Mist Inhalation Treatment" policy indicated the following:</p> <p>"...11. At the completion of the treatment assist the resident with mouth care and</p>						

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	<p>make comfortable.</p> <p>12. Disassemble the nebulizer, mouthpiece, mask, and T-piece and rinse with warm water. Allow the equipment to air dry completely, than place in a zip lock bag for storage for future use.</p> <p>13. Wash hands....."</p> <p>On 6/23/11 at 12:35 p.m. during an interview, the Director of Nursing indicated after checking with laundry, 58 residents presently residing in the facility had their personal laundry done by the facility.</p> <p>B. During a review of the provided Infection Control Program with the Director of Nursing on 6/23/11 at 8:15 a.m., the "Line Listing of Infections" form was reviewed. The form for April, May and June 2011 was incomplete in the following areas:</p> <p>April 2011: 16 of 39 of the resident infection listing lacked a room number for the resident. 4 of 39 of the resident infection listing lacked the type or evidence of the infection. 39 of 39 of the resident infection listing lacked the resolution of the infection</p>						

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	<p>May 2011:</p> <p>18 of 37 of the resident infection listing lacked a room number for the resident.</p> <p>7 of 37 of the resident infection listing lacked the type or evidence of the infection.</p> <p>37 of 37 of the resident infection listing lacked the resolution of the infection.</p> <p>June 2011:</p> <p>14 of 24 of the resident infection listing lacked a room number for the resident.</p> <p>4 of 24 of the resident infection listing lacked the type or evidence of the infection.</p> <p>24 of 24 of the resident infection listing lacked the resolution of the infection.</p> <p>The "Line Listing of Infection" log lacked any nosocomial or community acquired information, culture or lab results or isolation by unit or area in the building to utilize for tracking and trending purposes.</p> <p>At this time during interview, the Director of Nursing indicated the nurse who in charge of the program was on vacation. She indicated RN # 13 did not formally track or trend the infections. She indicated RN # 13 knows the residents and if there are patterns.</p> <p>3.1-18(b)(1)(A)</p> <p>3.1-18(b)(1)(B)</p>						

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F0502 SS=D	<p>3.1-18(b)(1)(C) 3.1-18(b)(3) 3.1-18(l) 3.1-19(g)</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure laboratory tests were obtained by the lab as ordered by the physician for 1 of 16 residents reviewed for laboratory test in a sample of 19. (Resident # 24)</p> <p>Findings Include:</p> <p>1. The record for Resident # 24 was reviewed on 6/20/11 at 11:30 a.m.</p> <p>A physician order dated 5/7/11, indicated an order for a Completed Blood Count (CBC).</p> <p>A physician order dated 6/1/11 indicated an order for a CBC and Basic Metabolic Panel (BMP).</p>			F0502	<p>F502</p> <p>I. Physician order was clarified for lab test for patient #24 and the lab test was obtained per current orders and plan of care.</p> <p>II. All patients with current lab orders were identified. These patients had current lab orders verified as needed and all lab tests provided as ordered.</p> <p>III. The systemic change includes that the clinical team will track all lab orders and results received in the morning clinical meeting Monday through Friday. The clinical team and charge nurses have been educated regarding the new system for tracking, requesting lab tests, receiving results and determining that all lab tests are completed as ordered.</p> <p>IV. Director of Nursing/designee</p>		07/23/2011

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	<p>The record lacked results of the above laboratory tests.</p> <p>On 6/21/11 at 4:45 p.m., additional information was requested from the Director of Nursing regarding the results of the above tests.</p> <p>On 6/22/11 at 8:50 a.m., during interview, the Director of Nursing provided dated lab orders for the above dates but indicated the lab had failed to draw the labs.</p> <p>3.1-49(a)</p>				<p>will complete a review of lab orders daily (Monday through Friday), once per week for the next month, then monthly for the next ten months to total twelve months of monitoring. These reviews will include that lab tests are completed timely as ordered and that results are obtained timely. Any identified concerns from audits will be addressed immediately. The results of these reviews will be reported to the Quality Assurance Committee.</p> <p>V. Completion date: 7/23/2011.</p>		